Maryland Learning Collaborative to Support Opioid Use Disorder Examination and Treatment Act and Medications for Addiction Treatment (MAT) Implementation for Justice-Involved Populations

MAT and Withdrawal Management
June 21, 2023

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- The American Academy of Family Physicians (AAFP) has reviewed Maryland Learning Collaborative to Support Act and MAT Implementation for Jurisdictions Learning Series and deemed it acceptable for AAFP credit. Term of approval is from 01/31/023 to 01/30/2024. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.
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  You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 10–12 business days of course completion.

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Nature of relationship	N/A	N/A	N/A	N/A

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GETTING TO KNOW EACH OTHER

Who is with us today?

- Please introduce yourself
- Your name, jurisdiction/location and role/position

Image Source: https://www.daterichmenclub.com/wp-content/uploads/2018/02/Getting-to-Know-Each-Other-1.jpg

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COACHING COMPONENTS: Addressing Act Requirements

- Medications for Addiction Treatment (MAT)
- Behavioral Health Interventions
- Screening and Assessment
- Peer Services
- Medicaid screening and enrollment processes
- Diversion/Medication Administration Integrity

TODAY'S LEARNING OBJECTIVES

1	Describe evidence-based, clinical management of opioid withdrawal
2	Compare and contrast use of buprenorphine versus comfort medications for withdrawal management
3	Describe management of concomitant opioid and alcohol withdrawal
4	Consider potential medical and behavioral complications for withdrawal management of opioid use disorder
5	Discuss strategies for implementing clinically appropriate care to support care in county jails

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QUESTION

Does your clinical setting use buprenorphine to manage opioid withdrawal?

a. Yes, routinely
b. Yes, sometimes depending
c. No

Please use the Zoom polling function to share your response.

CASE #1: OPIOID WITHDRAWAL MANAGEMENT

Ralph is a 24-year-old with no significant past medical history. He is detained in jail for retail theft.

On entry to jail, he admits to using Vicodin or heroin daily. When using Vicodin, he takes upwards of 10-20 tabs of 10 mg hydrocodone daily. He started taking this medication about 4 years ago after an injury where he fell off a ladder at work. When he cannot get Vicodin, he will snort heroin. His back and leg pain from the injury are manageable now but if he doesn't take the Vicodin, he has intolerable withdrawal symptoms and feels "like he is going to die." He has never used IV drugs.

He was in "rehab" once before where they weaned him off Vicodin, but he has never been on buprenorphine, methadone or naltrexone. His withdrawal symptoms are severe within 12 to 24 hours.

Image Source: https://encrypted-tbn3.gstatic.com/images?q=tbn:ANd9GcRZjkKBnl...SjNKPqxeg7Gv2Zy9VVtmodoQ8

CASE #1: DISCUSSION

- What should be his initial management? (buprenorphine vs "comfort medications")
- How frequently should opioid withdrawal evaluation be performed?
  - Clinical Opioid Withdrawal Scale (COWS)
- What would be a typical buprenorphine dose?

Sources:

1. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. Mar/Apr 2020;14(2S Suppl 1):1-91. doi: 10.1097/ADM.
2. Wesson DR, Ling W. (2003) The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs. 5(2):253-9. doi: 10.1080/02791072.2003.10400007. PMID: 12924748.
3. SAMHSA Pocket Guide
4. AddicitonFreeCA for Buprenorphine Quick Start Guide for Jails

CASE #1: CLINICAL TAKEAWAYS

- Urine drug testing (UDT) not needed to start buprenorphine
- Clinical Opioid Withdrawal Scale (COWS) tool for assessing severity of opioid withdrawal
  - Can be performed by trained custody, where medical services are not available 24/7
    - Threshold for medical intervention is appearing unwell to a lay person
  - Could be evaluated via Telehealth
- Buprenorphine better than "comfort meds"
- Ensure that dose of medication is sufficient to treat withdrawal and eliminate cravings

COWS

Pulse
Sweating
Restlessness
Pupil size
Bone and joint aches
Runny nose and tearing
GI upset
Tremor
Yawning
Anxiety & irritability
Gooseflesh

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CASE #2: STIMULANT WITHDRAWAL

Suzanne is a 36-year-old female smoker with history of mild asthma; she uses an inhaler 5-6 times per year.

She started using methamphetamines in her 20s when her kids were small. She worked night shift as a line manager in a local food processing plant and then had to stay awake during the day to take care of the kids. She started by taking meth orally to keep awake but her use accelerated over the past few years. She now typically snorts or smokes meth 3 times each day. She has never been to jail until now when she was arrested trying to sell meth.

She has had some increase in cavities/gum disease but says this is because she's not working and lost her dental insurance. She also has several itchy sores on her arms and legs and was treated by the local clinic for scabies, which didn't help. She is very anxious, asks repeated questions, paces in the holding area, has had angry outbursts at the staff accusing them of "targeting her" since she really isn't a dealer.

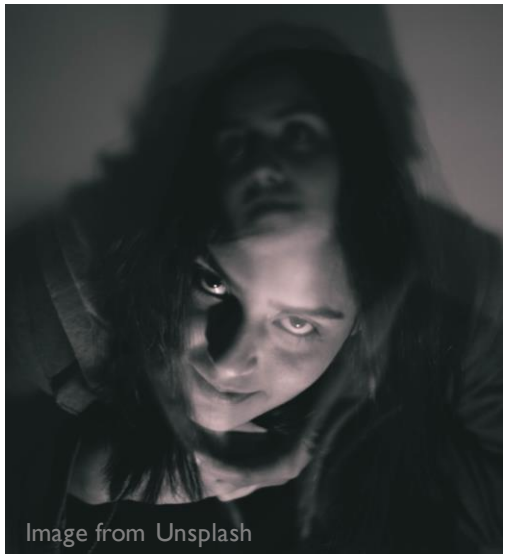

Image from Unsplash

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CASE #2: DISCUSSION

- Why is this case being presented in relation to HB 116 which focuses on MOUD?

- What is your initial management?
- What lab tests or UDT should be ordered?

Source:
Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020. https://store.samhsa.gov/product/Treatment-of-Stimulant-Use-Disorder/PEP20-06-01-001
AddictionFreeCA

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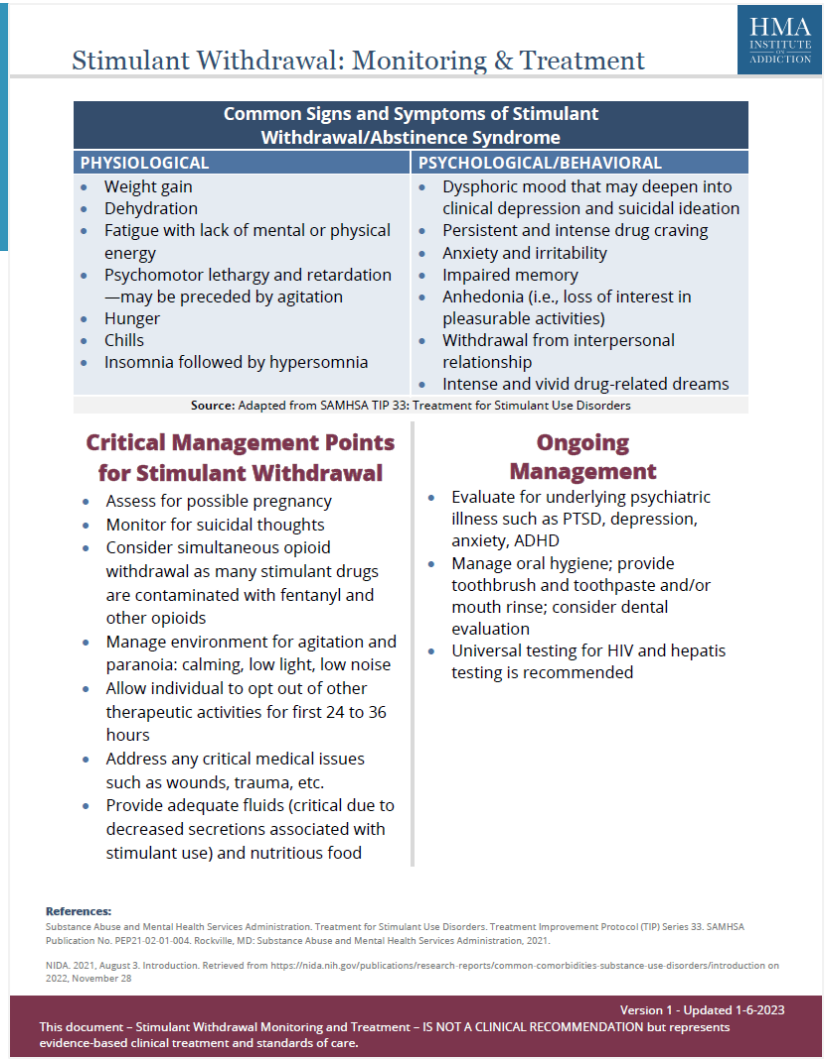
CASE #2: CLINICAL TAKEAWAYS

- Need to determine if fentanyl is present in methamphetamine
  - To determine if risk of opioid withdrawal or overdose
- Medication not available for stimulant withdrawal
- Management of symptoms and agitation necessary
- In withdrawal can go from agitated to withdrawn and there is an increased risk of suicide during both intoxication and withdrawal



Stimulant Withdrawal: Monitoring & Treatment

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Common Signs and Symptoms of Stimulant Withdrawal/Abstinence Syndrome

PHYSIOLOGICAL	PSYCHOLOGICAL/BEHAVIORAL
• Weight gain • Dehydration • Fatigue with lack of mental or physical energy • Psychomotor lethargy and retardation —may be preceded by agitation • Hunger • Chills • Insomnia followed by hypersomnia	• Dysphoric mood that may deepen into clinical depression and suicidal ideation • Persistent and intense drug craving • Anxiety and irritability • Impaired memory • Anhedonia (i.e., loss of interest in pleasurable activities) • Withdrawal from interpersonal relationship • Intense and vivid drug-related dreams

Source: Adapted from SAMHSA TIP 33: Treatment for Stimulant Use Disorders

Critical Management Points for Stimulant Withdrawal

- Assess for possible pregnancy
- Monitor for suicidal thoughts
- Consider simultaneous opioid withdrawal as many stimulant drugs are contaminated with fentanyl and other opioids
- Manage environment for agitation and paranoia: calming, low light, low noise
- Allow individual to opt out of other therapeutic activities for first 24 to 36 hours
- Address any critical medical issues such as wounds, trauma, etc.
- Provide adequate fluids (critical due to decreased secretions associated with stimulant use) and nutritious food

Ongoing Management

- Evaluate for underlying psychiatric illness such as PTSD, depression, anxiety, ADHD
- Manage oral hygiene; provide toothbrush and toothpaste and/or mouth rinse; consider dental evaluation
- Universal testing for HIV and hepatis testing is recommended

References:
Substance Abuse and Mental Health Services Administration. Treatment for Stimulant Use Disorders. Treatment Improvement Protocol (TIP) Series 33. SAMHSA Publication No. PEP21-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

NIDA. 2021, August 3. Introduction. Retrieved from https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/introduction on 2022, November 28

Version 1 - Updated 1-6-2023

This document – Stimulant Withdrawal Monitoring and Treatment – IS NOT A CLINICAL RECOMMENDATION but represents evidence-based clinical treatment and standards of care.

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CASE #3: OPIOID USE DISORDER & ALCOHOL USE DISORDER

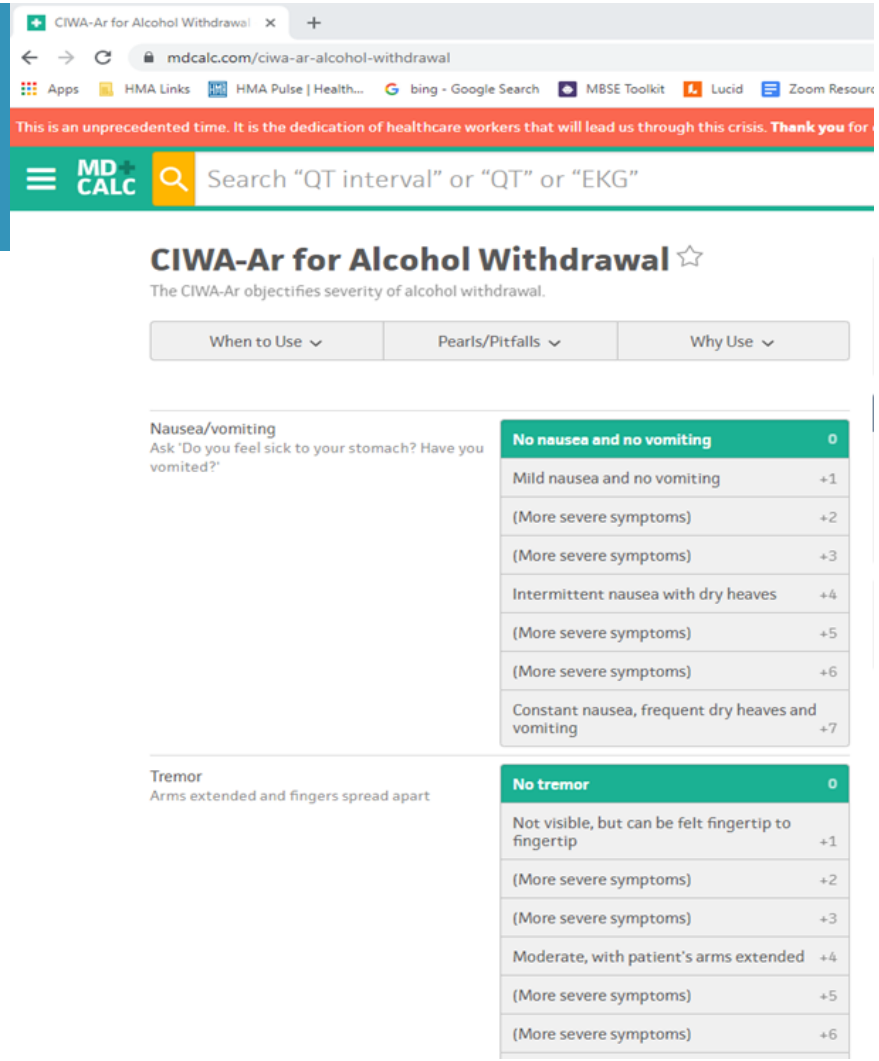
Joe is a 56-year-old nurse. He is admitted to the jail for a DUI to serve a 30-day sentence. He presents to the jail on Friday night. He smells of alcohol and is slurring his speech slightly. He says he drinks "3-6 beers" per night. He denies any other drug use. He is started on the jail's alcohol withdrawal protocol.

Approximately 12 hours later, despite alcohol withdrawal treatment, he reports worsening symptoms with nausea, agitation, muscle aches, and has a runny nose. He now reports that in addition to alcohol, he frequently takes "percs" that he buys online.

Image Source: https://www.niaaa.nih.gov/alcohols-effects-health/overview-alcohol-consumption/what-standard-drink

CASE #3: DISCUSSION

- What is a standard drink?
- What are best withdrawal monitoring tools?
  - Clinical Institute Withdrawal Assessment- Alcohol Revised (CIWA-AR)
  - COWS
- How does combined withdrawal manifest and make management more complicated?
- What are key red flags for acute management and transfer to higher level of care?



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CASE #3: CLINICAL TAKEAWAYS

- Alcohol withdrawal requires rigorous monitoring because of higher risk of death
- Combined withdrawal is the "norm" not the exception
- Higher level of care indicators/processes is best practice

Sources:

1. American Society of Addiction Medicine. (2020). *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*. American Society of Addiction Medicine, Inc.
2. Elefante RJ, Batkis M, Nelliot A, Abernathy K, Rocha K, Jenkins F, Rastegar DA, Neufeld KJ. Psychometric Properties of the Revised Clinical Institute Withdrawal Alcohol Assessment and the Brief Alcohol Withdrawal Scale in a Psychiatric Population. J Addict Med. 2020 Dec;14(6):e355-e358.
3. The Alcohol Use Disorder: Withdrawal Management webinar can be viewed HERE
4. Department of Justice Bureau of Justice Assistance, Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Healthcare Professionals

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CASE #4: BEHAVIORAL HEALTH & OUD

Rory is a 22-year-old male who was in community college but increasingly became isolated and spent all his time online. He started being aggressive at home when his parents would ask him to do chores or shower, so his parents asked him to leave the house. Rory has been staying at homeless shelters and living in a local parking garage. He has been arrested a few times for public urination and was diverted to a crisis BH program. He was started on quetiapine for psychosis but has been only partially adherent.

Rory has been working on creating a video game and he thinks the quetiapine is designed to "slow him down" so that other people can steal his video game ideas. He is on the waiting list for assertive community treatment services. He was arrested for loitering at a local store and aggressively approaching customers to carry their bags for money often snatching the bags out of the customers' hands. He has a bottle of pills on him on entry to the jail and reports that these are "medications" that he takes that "work better" than quetiapine and he gets these "from his friends" in the parking garage. He doesn't know what they are.

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CASE #4: DISCUSSION

- What is the first step for management at the jail?
- How can his "pills" be identified?
- How does potential withdrawal impact psychosis and vice versa?

18 million adults in 2021 had an **acute mental illness** and drug or alcohol use disorder in the past year.
53% received services for either condition; 84% received ONLY MH services.

Among 6 million adults in 2021 with **serious mental illness** and drug or alcohol use disorder.
67% received treatment for either, but 82% received ONLY MH treatment.

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CASE #4: CLINICAL TAKEAWAYS

- Co-occurring SUD and mental illness is common
- Drug use can exacerbate MH symptoms and vice versa
- Team-based care important
- Matching BH intervention to patient's goals important to fostering trust and eventual acceptance of treatment

Sources:

SAMHSA. (2020). Substance use disorder treatment for people with co-occurring disorders. Treatment improvement protocol (TIP) series 42. Health Services Administration. HHS Publication No. (SMA) 13-4801. Rockville, MD. Substance Abuse and Mental Health Services Administration.
https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004

SAMHSA. (2022). Highlights from the 2021 National Survey on Drug Use and Health. Rockville, MD. Substance Abuse and Mental Health Services Administration.
https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlights092722.pdf

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- Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.
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- AddictionFreeCA.org
  - Opioid Withdrawal Webinar 2020
  - Alcohol Withdrawal Webinar 2021
  - Stimulant Use Disorders Webinar 2021
  - Buprenorphine Quick Start for Jails Handout 2023
  - Stimulant Withdrawal Monitoring and Treatment Handout 2023

QUESTIONS AND DISCUSSION

QUICK EVALUATION POLL

Overall, today's training session was:

- Very useful
- Somewhat useful
- Not very useful
- Not useful at all

The material presented today was:

- At the right level
- Too basic
- Too detailed

EVALUATION

CONTACT US

FOR ANY QUESTIONS OR COMMENT

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